A Publication of the 18th MEDCOM Preventive Services Directorate
"Preserving the Fighting Strength"

UPDATE

Disease Non-battle Injury in the Korean Theater

No. 1; Vol. 1
January 2002

INTRODUCTION

Welcome to the first edition of the 'DNBI Update.' This publication is meant to provide information for health care workers and commanders regarding the incidence of disease and injury among service members here on the peninsula. We feel this is an important service for several reasons.

Without information about what is making soldiers ill, keeping them healthy is more difficult. Prevention programs can't work without a clear target.

At the same time, we can't tell how well any prevention programs are working without information on the conditions in question.

Keeping you up to date on 'what's out there' helps soldiers and family members get appropriately diagnosed and treated. Training schedules and other duties can be appropriately adjusted for maximal unit benefit and the least soldier risk.

This publication will also include information on public health matters among the civilian Korean population, too, in our efforts to keep you better informed of threats to family and service member health.

Please keep in mind this edition represents the beginning, and to paraphrase a favorite author, "All beginnings are hard." As our surveillance projects get underway, we plan to expand the topics addressed to create a publication to better fit the needs of our audience. However, your feedback and submissions are very welcome. Please address any comments or ideas for future issues to Laura.Pacha@kor.amedd.army.mil.

SHIGELLA OUTBREAK

In the early part of December, the Republic of Korea experienced an outbreak of dysentery, a bacterial diarrheal disease caused by Shigella. Over 800 persons reported to health care facilities with symptoms of fever, watery and/or bloody diarrhea and/or abdominal cramps. The outbreak was confined mostly to parts of Seoul and Chuncheon. National Institute of Health, Korea (KNIH) officials traced the outbreak source to a box lunch factory in the Seodaemun area. Three ill employees continued to work, making kimbap. Officials estimated that possibly up to 7,000 box lunches were potentially contaminated with the organism.

Shigella Outbreak

continued from page 1

Cases occurring in the Chuncheon area were related to a school trip to a museum in Seoul. While at the museum, the children were fed box lunches from this company. Many developed symptoms after they returned home. It is felt the ill children then spread the disease to household members and other contacts who did not attend the trip or eat the lunches.

This outbreak illustrates the importance of proper hygiene and handwashing in the prevention of disease. Shigella outbreaks occur frequently in Korea, especially during the summer months. Food handlers are reminded to refrain from direct food contact while ill. Ill personnel can be assigned other administrative duties until cleared to return to work.

No cases of dysentery have been reported among USFK personnel or family members during this time.

RABIES

While the Republic of Korea had been enjoying a respite from the threat of rabies in the animal population for several decades, this fatal disease has begun a comeback amongst roaming dogs, cattle and raccoons. While all reported cases have occurred in the Kyonggi and Kangwon Provinces near the DMZ, precautions must be taken throughout the peninsula. This month the first human fatality in this country in over twenty years was reported to the KNIH in the Kangwon province.
Providers are encouraged to provide rabies prophylaxis and vaccination for individuals bitten by at-risk animals. The vaccination status of the biting animal, in conjunction with the size and location of the bite determines the need for prophylaxis. This is summarized below in a chart from the CDC:

Rabies postexposure prophylaxis guide – United States, 1999

Animal type	Evaluation and disposition of animal	Postexposure prophylaxis recommendations
Dogs, cats, and ferrets	1. Healthy and available for 10 days observation	1. Persons should not begin prophylaxis unless animal develops clinical signs of rabies.*
	2. Rabid, suspected rabid, or unknown vaccine status	2. Immediately vaccinate. Consult public health officials.
Skunks, raccoons, foxes and most other carnivores; bats	Regarded as rabid unless animal proven negative by laboratory tests+	Consider immediate vaccination.
Livestock, small rodents, lagomorphs (rabbits and hares), large rodents (woodchucks & beavers) and other mammals.	Consider individually.	Consult public health officials. Bites of squirrels, hamsters, guinea pigs, gerbils chipmunks, rats, mice, other small animals almost never require antirabies postexposure prophylaxis.

* During the 10-day observation period, begin postexposure prophylaxis at the first sign of rabies in a dog, cat or ferret that has bitten someone. If the animal exhibits clinical signs of rabies, it should be euthanized immediately and tested.
+The animal should be euthanized and tested as soon as possible. Holding for observation is NOT recommended. Discontinue vaccine if immunofluorescence test results of the animal are negative.

Additional information regarding rabies prophylaxis protocols is included below:

Rabies postexposure prophylaxis schedule – United States, 1999

Vaccination status	Treatment	Regimen*
Not previously vaccinated	Wound cleansing	All postexposure treatment should begin with immediate thorough cleansing of all wounds with soap and water. If available, a virucidal agent such as a povidone-iodine solution should be used to irrigate the wounds.
	RIG	Administer 20 IU/kg body weight. If anatomically feasible, the full dose should be infiltrated around the wound(s) and any remaining volume should be administered IM at an anatomical site distant from vaccine administration. Also, RIG should not be administered in the same syringe as vaccine. Because RIG might partially suppress active production of antibody, no more than the recommended dose should be given.
	Vaccine	∆ HDCV, RVA , or PCEC 1.0 mL, IM (deltoid area+),one each on days 0, 3, 7, 14, and 28.
e Previously vaccinated	Wound cleansing	All postexposure treatment should begin with immediate thorough cleansing of all wounds with soap and water. If available, a virucidal agent such as a povidone-iodine solution should be used to irrigate the wounds.
	RIG	RIG should not be administered.
	Vaccine	∆ HDCV, RVA, or PCEC 1.0 mL, IM (deltoid area+),one each on days 0 and 3.

HDCV=human diploid cell vaccine; PCEC=purified chick embryo cell vaccine; RIG=rabies immune globulin; RVA=rabies vaccine adsorbed; IM, intramuscular.

* These regimens are applicable for all age groups, including children.

+ The deltoid area is the only acceptable site of vaccination for adults and older children. For younger children, the outer aspect of the thigh may be used. Vaccine should never be administered in the gluteal area.

∆ Day 0 is the day the first dose of vaccine is administered.

e Any person with a history of preexposure vaccination with HDCV, RVA or PCEC; prior postexposure prophylaxis with HDCV, RVA, or PCEC; or previous vaccination with any other type of rabies vaccine and a documented history of antibody response to the prior vaccination.

All animal bites are to be reported on DD2341. These reports are immediately forwarded to the local veterinarian, who will make arrangements to quarantine the involved animal if possible. They can also be consulted regarding the need for rabies prophylaxis in the bitten person. The report is then forwarded to the local preventive medicine department for review.
Veterinary Clinic numbers are: Yongsan: 738-5144, Osan: 784-6614, Taegu: 764-4858, Pusan: 763-7220, and CRC: 732-7434. For questions on the human aspects of rabies your local preventive medicine professional can provide assistance or you may contact the Preventive Medicine Consultant at 736-3025. The Center for Disease Control and Prevention has a comprehensive educational site which includes rabies prophylaxis recommendations at: http://www.cdc.gov/ncidod/dvrd/rabies/.

COLD WEATHER INJURIES

Now that the snows have begun, all providers are again reminded to report all cold weather injuries (CWIs) seen in their clinics. While the protection of soldiers against cold weather injuries is a command responsibility, Army Medical Department personnel must assist commanders in defining risks, developing sound plans and programs, and assuring these are consistently implemented. Unit surgeons, preventive medicine sections, and all medical personnel serving in an advisory capacity to Army units must take a proactive role in assuring that our leaders know about and support efforts to prevent cold weather injuries. Provider reporting is crucial for the assessment of prevention programs. A copy of the Reportable Events Worksheet is included at the end of this publication.

New Wind Chill Temperature Index

A new Wind Chill Temperature index has been developed by several weather-related agencies in North America. The new index was developed in response to widespread recognition of the inaccuracy of existing wind chill charts, which tend to overestimate the effect of wind. The new index has been adopted for use during the 2001-2002 winter season by a number of meteorological organizations including the National Weather Service and the US Air Force Weather Agency. As a result, the new wind chill chart will be used by weather-monitoring activities on military installations worldwide. The U.S. Army Research Institute for Environmental Medicine has incorporated the new wind chill temperature chart into an updated Technical Note - "Sustaining Health and Performance In Cold Weather Operations," October 2001. An excerpt of the new wind chill temperature chart and guidance related to its use is included here.

Wind Speed (mph) ↓	Air Temperature (°F)																	
	40	35	30	25	20	15	10	5	0	-5	-10	-15	-20	-25	-30	-35	-40	-45
5	36	31	25	19	13	7	1	-5	-11	-16	-22	-28	-34	-40	-46	-52	-57	-63
10	34	27	21	15	9	3	-4	-10	-16	-22	-28	-35	-41	-47	-53	-59	-66	-72
15	32	25	19	13	6	0	-7	-13	-19	-26	-32	-39	-45	-51	-58	-64	-71	-77
20	30	24	17	11	4	-2	-9	-15	-22	-29	-35	-42	-48	-55	-61	-68	-74	-81
25	29	23	16	9	3	-4	-11	-17	-24	-31	-37	-44	-51	-58	-64	-71	-78	-84
30	28	22	15	8	1	-5	-12	-19	-26	-33	-39	-46	-53	-60	-67	-73	-80	-87
35	28	21	14	7	0	-7	-14	-21	-27	-34	-41	-48	-55	-62	-69	-76	-82	-89
40	27	20	13	6	-1	-8	-15	-22	-29	-36	-43	-50	-57	-64	-71	-78	-84	-91
45	26	19	12	5	-2	-9	-16	-23	-30	-37	-44	-51	-58	-65	-72	-79	-86	-93
50	26	19	12	4	-3	-10	-17	-24	-31	-38	-45	-52	-60	-67	-74	-81	-88	-95

Wind speed based on measures at 33 feet height. If wind speed measured at ground level multiply by 1.5 to obtain wind speed at 33 feet and then utilize chart.

WCT (°F) = 35.74 + 0.6215T - 35.75($V^{0.16}$) + 0.4275T($V^{0.16}$), where T is temperature (°F) and V is wind speed (mph)

ASSESSING RISK OF FROSTBITE

GREEN – LITTLE DANGER (frostbite occurs in >2 hours in dry, exposed skin)
YELLOW – INCREASED DANGER (frostbite could occur in 45 minutes or less in dry, exposed skin)
RED – GREAT DANGER (frostbite could occur in 5 minutes or less in dry, exposed skin)

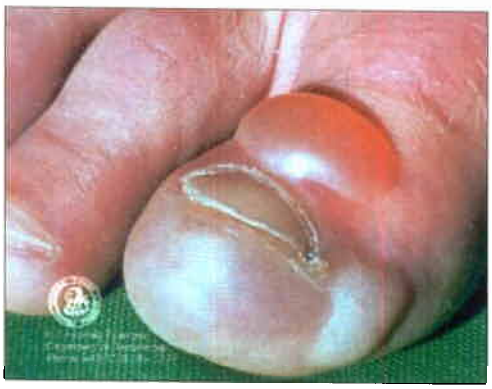
Time to occurrence of frostbite in minutes or hours in the most susceptible 5% of personnel.*

Wind Speed (mph) ↓	Air Temperature (°F)											
	10	5	0	-5	-10	-15	-20	-25	-30	-35	-40	-45
5	>2h	>2h	>2h	>2h	31	22	17	14	12	11	9	8
10	>2h	>2h	>2h	28	19	15	12	10	9	7	7	6
15	>2h	>2h	33	20	15	12	9	8	7	6	5	4
20	>2h	>2h	23	16	12	9	8	8	6	5	4	4
25	>2h	42	19	13	10	8	7	6	5	4	4	3
30	>2h	28	16	12	9	7	6	5	4	4	3	3
35	>2h	23	14	10	8	6	5	4	4	3	3	2
40	>2h	20	13	9	7	6	5	4	3	3	2	2
45	>2h	18	12	8	7	5	4	4	3	3	2	2
50	>2h	16	11	8	6	5	4	3	3	2	2	2

***WET SKIN CAN SIGNIFICANTLY REDUCE THE TIME FOR FROSTBITE TO OCCUR.**

Types of Cold Weather Injuries

Cold weather injuries occur in a spectrum from non-freezing to freezing injuries and then to general hypothermia. Below is a quick summary of the CWI spectrum and treatment. For more detailed information, contact Laura.Pacha@seoul.amedd.army.mil or HeeChoon.Lee@seoul.amedd.army.mil. CWI training presentations are available.



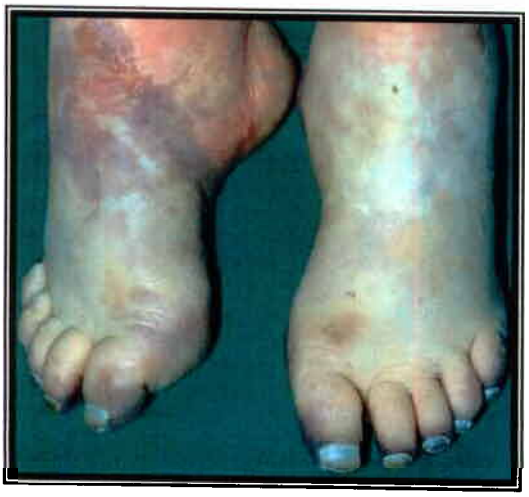
Above: Examples of skin changes with moderate & severe frostbite.

Non Freezing Injuries

- **Chillblain**
  - Appear as swollen, tender, erythematous papules with desquammation and bleeding
  - Complaint of pruritus, burning or prickly sensation
  - Mostly females
  - Treatment Options: Ideally, passive warming at room temp without rubbing or massage. Affected areas should be protected from trauma and secondary infection. Topical steroids may help, while Prazosin, 1 mg daily may prevent reoccurrence
- **Trench/Immersion foot**
  - Due to prolonged contact with moisture at temps between 32-50°F
  - **First Phase**-feet appear pale, waxy, mottled, pulseless, anesthetic and immobile
  - **Second phase**: hyperemia after rewarming for 1-2 days with severe, burning pain

Only diagnose when these signs **do not change after initial warming**

NOTE: Moderate to severe trench/immersion foot may present with edema, hyperemia, bullae and mottling; gangrene may develop, leading to loss of deep and superficial tissue. This can permanently disable and prevent RTD!



Freezing Injuries

*Note: Classification is based on the clinical appearance 2-3 days **after** injury*

- **Frostnip**
  - Aka 1st degree frostbite: the most superficial form resulting in pale or red appearance, mild swelling, edema, & paresthesias in affected parts. Symptoms resolve in hours to days without sequelae or treatment
- **Frostbite--True** freezing injury of tissues
  - Minimal Hyperemia and slight sensory changes. No objective findings.
  - Mild Edema, hyperemia and clear sensory changes. No bullae or skin loss.
  - Moderate-Severe Bullae and tissue necrosis develop

Keys to treatment include rewarming **WITHOUT** refreezing. Massaging or rubbing affected areas will cause more tissue damage. If rewarming cannot be maintained (i.e., at field sites) it is generally better to **NOT** attempt rewarming. Partial thawing with refreezing only extends the tissue damage. Concomitant evaluation for hypothermia and dehydration is also indicated.

Hypothermia

- **Mild** (Core Temperature 98.6-91.4°F)
  Symptoms include shivering, dysarthria, and mild ataxia with concomitant personality changes-neurosis, apathy, moodiness. Skin is pale and cold. The person may complain of hunger, nausea, and/or fatigue. However, these symptoms resolve with rewarming, and the person can usually resume activities if they will be well insulated and hydrated.
- **Moderate-Severe** (Core Temperature 80.6-89.6°F)
  This degree of hypothermia is a medical emergency. Symptoms include more severe mental status changes--stuporous to unconscious; the loss of the shivering reflex; and even arrythmias such as atrial fibrillation or severe bradycardia. Opiate effects (dilated pupils, bradypneia, hypotension) are also seen. Therefore, treatment with Naloxone may be of benefit.

Keys to treatment include **GENTLE** handling and immobilization to reduce risk of triggering ventricular fibrillation; warm rehydration but **NO LR** or other lactate-containing solutions, as a cold liver cannot metabolize lactate. In addition, evaluation and treatment for hypoglycemia may be indicated. Of note, patients with significant hypothermia must be transported **prior to** warming attempts.

DISEASE TRENDS

18th MEDCOM Reportable Events Program

Selected Reportable Events Summary
NOV-DEC 2001

Reportable Condition	Area I	Area II	Area III	Area IV	Totals
Trichomonas	NR	NR	NR	1*	1*
Chlamydia[1]	30	33	16	8	87
Herpes simplex	NR	NR	1*	NR	1*
Gonorrhea[1]	11	7	9	1	28
STD Totals	41	40	26	10	117
Tuberculosis (active disease)	1	0	0	0	1
Tuberculosis (recent converter)	-*	3*	5*	8*	16*
Salmonellosis	NR	2	NR	NR	2
Suicide Gesture/Attempt	NR	0	NR	NR	0
Deaths from all causes	NR	2	NR	NR	2

In the interest of space, reportable conditions with zero incidence for the period of interest are not listed here. Refer to the reverse of the 18th MEDCOM IHO Reportable Events Worksheet for a complete listing. A copy of this form is included at the end of this document.

NR=None Reported

*Indicates only NOV data available.

[1]Numbers based on CHCS lab results

Reported Events Summary

Conditions		Cum 2001	Cum 2000
STD	Chlamydia	45	58
	Gonorrhea	26	5
	Herpes Type II	2	
	HIV/AIDS		
	Pelvic Inflammatory Disease		
	Non-Gonococcal Urethritis	2	
	Syphilis	1	4
Infectious Diseases	Campylobacter		
	Cholera		
	E.Coli 0157:H7		
	Encephalitis		
	Giardiasis		
	Hepatitis A		
	Hepatitis B		
	Hepatitis C		
	Influenza		
	Measles		3**
	Meningitis	1	
	Pneumococcal Pneumonia		
	TB, Active	1	
	PPD Conversion	19	
	Salmonellosis	3	2
	Shigellosis		
	Typhoid Fever		
	Varicella, adult	2	1
Vector-borne Diseases	Dengue Fever		
	Ehrlichiosis		1
	HFRS		
	Japanese Encephalitis		
	Leptospirosis		
	Malaria	12 (12^)	16 (24^)
	Rabies		
	Scrub Typhus		
Injuries	Animal Bites	1	
	Cold Injury		
	Heat Injury	5	
	CO Poisoning		
	Lead poisoning		
	Snake Bites		
	Hearing Loss		
Immunization	VAERS		
	Influenza		

Note: empty cells indicate NO reported cases; filled cells indicate # cases reported; more may have been diagnosed but not reported

***All cases occurred in KATUSA soldiers*
^Indicates additional cases diagnosed after patient returned to US from Korea

EAMC FORM 600, NOV 2001

18th MEDCOM IHO REPORTABLE EVENTS WORKSHEET

PATIENT DATA

Last Name

First Name

FMP

Social Security Number ___ — ___ — ____

Date of Birth ___ (Day) ___ (Month) ___ (Year)

Residence - City or Location (*e.g.* Yongsan)

Gender: O MALE O FEMALE

APO

Race: O WHITE O ASIAN O BLACK O AM. INDIAN O HISPANIC O OTHER

Category* **Grade** **Unit** **UIC**

Unit Location - (*e.g.* CP Casey)

Duty Phone ___ — ____

REPORTING SOURCE

Submitting Health Care Provider: _____

CHN/Clinic: _____

Phone #: _____

Comments/Additional Information:

1. Refer to the list on the back of this form to determine if a patient's disease/condition is reportable.
2. Complete one worksheet per disease (vs. per patient in cases of multiple diagnoses) while the patient is still present.
3. Indicate if the disease/condition is suspected or confirmed and what testing has been done (i.e., culture, serology, etc.). Community Health Nursing personnel will help track the results.
4. Diseases/conditions followed by an asterisk (*) also require immediate telephone reporting to your Area Community Health Nurse to initiate disease control measures (Area I 730-6796, Area II 725-5128, Area III 753-8355, Area IV 764-4819). After duty hours, contact the Community Health Nursing Consultant through the 121st General Hospital Emergency Department.
5. Forward completed worksheets to Commander, 18th MEDCOM, Attn: EAMC-CHN, APO AP, 96205-0020 or FAX to 736-3028.

HEAT OR COLD INJURIES ONLY

Ambient temperature ___.___ °C / °F

Wind Speed ___ MPH

Rectal temperature ___.___ °C / °F

WBGT ___.___

Body Part or Organ System Affected: _____

Ephedra Use: O YES O NO

Previous Heat or Cold injury: O YES O NO

Multi-system involvement: O YES O NO

MALARIA CASES ONLY

Pertinent Travel: O YES O NO

Country #1 _____

Country #2 _____

Malaria Chemoprophylaxis: O YES O NO

Prophylaxis #1 _____

Prophylaxis #2 _____

18th MEDCOM IHO REPORTABLE EVENTS WORKSHEET

DISEASE DATA

Diagnosis (See Reverse for Malaria & Heat/Cold Injuries)

Onset of Symptoms

Day ☐☐ Month ☐☐ Year ☐☐☐☐

Confirmed:
- O YES
- O NO
- O PENDING

Method of Confirmation:
- O CLINICAL
- O CULTURE
- O SLIDE
- O BIOPSY
- O SEROLOGY
- O OTHER

Admitted:
- O YES
- O NO

Date of Admission

Day ☐☐ Month ☐☐ Year ☐☐☐☐

REPORTABLE CONDITIONS LISTS

TRI-SERVICE

Amebiasis
Anthrax
Biological warfare agent exposure
Botulism
Brucellosis
Campylobacter
Carbon monoxide poisoning
Chemical agent exposure
Chlamydia
Cholera*
Coccidiomycosis
Cold injury, frostbite
Cold injury, hypothermia
Cold injury, immersion type
Cold weather injury, unspecified
Cryptosporidiosis*
Cyclospora
Dengue fever*
Diphtheria*
E. coli O154:H7*
Ehrlichiosis
Encephalitis*
Filariasis
Giardiasis
Gonorrhea
Haemophilus influenza, invasive
Hantavirus infection
Heat exhaustion
Heat stroke
Hemorrhagic fever
Hepatitis A, Acute
Hepatitis B, Acute*
Hepatitis C, Acute
Influenza
Lead poisoning
Legionellosis
Leishmaniasis, cutaneous*
Leishmaniasis, mucocutaneous*
Leishmaniasis, unspecified*
Leishmaniasis, visceral*
Leprosy
Leptospirosis
Listeria
Lyme disease
Malaria, falciparum
Malaria, malariae
Malaria, ovale
Malaria, unspecified
Malaria, vivax
Measles*
Meningococcal dis., Meningitis
Meningicoccal dis., Septicemia
Mumps*
Pertussis*
Plague*
Pneumococcal pneumonia
Poliomyelitis*
Q fever
Rabies, human
Relapsing fever
Rheumatic fever, Acute
Rift Valley fever
Rocky Mountain Spotted fever
Rubella*
Salmonellosis
Schistosomiasis*
Shigellosis*
Smallpox
Streptococcus, Grp. A, invasive
Syphilis, congenital
Syphilis, latent
Syphilis, late (tertiary)
Syphilis, primary/secondary
Syphilis, unspecified
Tetanus*
Toxic shock syndrome
Trichinosis
Trypanosomiasis
Tuberculosis, pulmonary
Tularemia
Typhoid fever
Typhus fever
Urethritis, non-gonococcal
Vaccine, adverse event
Varicella, active duty only
Yellow Fever

KOREA-SPECIFIC

Asbestosis
Chancroid
Contagious disease in day care
Granuloma inguinale
HIV/AIDS
Lymphogranuloma venereum
Melioidosis
Pelvic inflammatory disease
Rash outbreak
Rhabdomyolysis
Trichomoniasis
URI outbreak

KOREA Ministry of Health and Welfare Required

African sleeping sickness*
Angiostrongyliasis
Babesiosis*
Chagas diasese
Dengue fever
Ebola fever*
Echinococcosis
Gnathostomiasis
Lassa fever*
Marburg fever*
Newly emerging syndromes*
- Acute neurological disorders
- Acute respiratory symptom
- Acute diarrhea
- Acute hemorrhagic fever
- Acute jaundice

Paratyphoid fever*
Pinta*
Scarlet fever
Vancomycin Resistant Staphlococcus Aureus
Vibrio vulnificus infection
Yaws*

CATEGORY CODES

A11	Army active duty	F41	DEP Air Force active duty	N11	Navy active duty
A31	Army retired	F43	DEP Air Force retired	N31	Navy retired
A41	DEP Army active duty	M11	Marine active duty	N41	DEP Navy active duty
A43	DEP Army retired	M31	Marine retired	N43	DEP Navy retired
F11	Air Force active duty	M41	DEP Marine active duty	K59	Civilian/DEP Civilian
F31	Air Force retired	M43	DEP Marine retired	K79	Local National

PRIVACY ACT INFORMATION

Authority: Section 133, Title 10, United States Code (10 USC 133)
Purpose: The purpose of this form is to compile relevant patient information concerning communicable diseases and injuries occurring among Department of Defense personnel and family members stationed or operating in Korea.
Routine Uses: Used to monitor for the emergence of specific communicable diseases or outbreaks which pose a public health threat and to prepare data for inclusion in the U.S. Army Medical Surveillance System.
Disclosure: The requested information is mandatory for compliance with U.S., Host Nation and Army disease reporting laws and regulations. Failure to provide the requested information will prevent effective public health action and contribute to higher disease and injury rates.

REPORT OF ANIMAL BITE - POTENTIAL RABIES EXPOSURE

(Please read Privacy Act Statement on back before completing this form.)

SEQUENCE NUMBER

1. FROM *(Medical Treatment Facility)*	2. THRU *(Deputy Commander for Veterinary Services)*	3. TO *(Chief, Preventive Medicine)*

PART I - ANIMAL BITE HISTORY *(To be completed by Emergency Room Interviewer)*

4. DESCRIPTION OF ANIMAL

a. TYPE *(Dog, cat, etc.)*	b. BREED	c. SIZE	d. COLOR	e. SEX

5. TIME OF ATTACK

a. DATE	b. HOUR

6. PRESENT LOCATION OF ANIMAL OR GEOGRAPHIC ADDRESS WHERE ATTACKED ☐ ON POST ☐ OFF POST

7. CIRCUMSTANCES LEADING TO BITE/SCRATCH INCIDENT

8. APPARENT HEALTH OF ANIMAL *(Unusual Behavior)*

9. OWNER

a. NAME *(Last, First, Middle Initial)*	b. STATUS *(X one)*	c. PHONE NUMBER *(Include Area Code)*	d. ADDRESS *(Street, City, State, Zip Code)*
	☐ MILITARY ☐ CIVILIAN		

10. RABIES VACCINATION

a. VACCINATION STATUS OF ANIMAL	b. YEAR ANIMAL VACCINATED	c. TYPE VACCINE *(If known)*

11. PREPARED BY

a. NAME *(Last, First, Middle Initial)*	b. TITLE	
c. SIGNATURE	d. DEPARTMENT/SERVICE/CLINIC	e. DATE PREPARED

PART II - MANAGEMENT OF ANIMAL BITE CASE *(To be completed by Medical Officer (Information from SF 600))*

12. DESCRIPTION OF INJURY AND LOCATION ON THE BODY

13. DIAGNOSIS *(Injury) (X, as applicable)*

☐ ANIMAL BITE ☐ CLAW WOUND ☐ OTHER

14. RABIES RISK ESTIMATE *(X one)*

☐ MINIMAL ☐ MODERATE ☐ HIGH RISK

15. INITIAL TREATMENT GIVEN

a. TIME	b. DATE

- ☐ c. DEEP FLUSHING AND CLEANSING WITH SOAP AND WATER
- ☐ d. TETANUS TOXOID *(List dose given)*
- ☐ e. OTHER *(Specify)*

16. RECOMMENDED FURTHER PROPHYLACTIC TREATMENT

- ☐ a. NONE
- ☐ b. *HUMAN RABIES IMMUNE GLOBULIN
- ☐ c. HUMAN DIPLOID CELL RABIES VACCINE
- ☐ d. COUNSELED ON DF2 HAZARD
- ☐ e. OTHER *(Specify)*

**Need to consult Rabies Board prior to treatment*

17. PATIENT'S IDENTIFICATION *(ID impression, if available.)*
(For typed or written entries give name (Last, First, Middle Initial); pay grade; SSN; unit; phone; date; hospital or medical facility.)

18. PHYSICIAN

a. NAME *(Last, First, Middle Initial)*

b. SIGNATURE

19a. DISCUSSED WITH AREA VETERINARIAN *(X one)* ☐ YES ☐ NO

b. NAME OF VETERINARIAN *(Last, First, Middle Initial)*

20. VERBAL REPORT TO	(1) NAME	(2) PHONE NO.
a. VETERINARIAN		
b. POLICE		
c. OTHER		

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, United States Code, Sections 3013, 5013, and 8013.

PRINCIPAL PURPOSE(S): Used by medical authorities to record the history, examination, and treatment of a person who has possibly been exposed to rabies; and to record the follow-up medical care provided to the individual who was either bitten or scratched. Used by veterinarians to locate the animal, record examination, observations, and disposition results, and possible laboratory findings for the animal.

ROUTINE USE(S): Information will be used as a basis for documenting the proper treatment and care of individuals who have potentially been exposed to rabies. The information will be used to locate the animal, and record the vaccination and physical status of the involved animal. The information may also be used to: aid in preventive health and communicable disease control programs; report medical conditions required by law to Federal, state and local agencies; compile statistical data; conduct research; teach; assist in law enforcement, to include investigation and litigation; and to evaluate the care provided.

DISCLOSURE: Voluntary; however, if the information is not provided, it will delay the compilation of the data required for record keeping purposes.

PART III - MANAGEMENT OF BITING ANIMAL *(To be completed by Veterinarian)*

21. AUTHORITIES NOTIFIED

a. NAME *(Last, First, Middle Initial)*	b. DATE	c. TIME	d. INITIALS	e. FOLLOW-UP	
				(1) DATE	(2) TIME

22. INITIAL ACTION

23. EMERGENCY ROOM NOTIFIED

a. TIME	b. DATE	c. INITIALS

24. LOCATION OF ANIMAL DURING OBSERVATION PERIOD *(On or off post, list point of contact if not veterinary activity)*

25. OBSERVED BY *(Include name of military or civilian agency)*

26. DATES OBSERVED

a. FROM	b. TO

27. DATE ANIMAL RELEASED

28. CONDITION OF ANIMAL DURING AND AT THE END OF 10-DAY QUARANTINE

29. OTHER DISPOSITION OF ANIMAL *(Explain fully - died, escaped, not located, etc.)*

30. LABORATORY FINDINGS OF ANIMAL SUBMITTED FOR RABIES DIAGNOSIS

a. TEST *(X one)*	b. DATE RECEIVED	c. RESULTS *(X one)*			
(1) FLUORESCENT ANTIBODY			NEGATIVE		POSITIVE
(2) CELL CULTURE			NEGATIVE		POSITIVE

31. INFORMATION REPORTED TO RABIES BOARD BY

a. NAME *(Last, First, Middle Initial)*	b. SIGNATURE	c. DATE SIGNED

32. VETERINARY OFFICER

a. NAME *(Last, First, Middle Initial)*	b. SIGNATURE	c. DATE SIGNED

PART IV - RABIES ADVISORY TEAM ACTION/BOARD REVIEW

33. DISCUSSED BY *(List names of members of team or board, or X box at right.)* ☐ NOT REQUIRED TO MEET

34. RECOMMENDATIONS

	a. HUMAN RABIES IMMUNE SERUM *(X one)*		LOCAL		SYSTEMIC		BOTH
	b. VACCINE						
	c. OTHER						

35. CHIEF, PREVENTIVE MEDICINE

a. NAME *(Last, First, Middle Initial)*	b. SIGNATURE	c. DATE SIGNED

36. FINAL DISPOSITION OF CASE *(Review by rabies board)*

37. PRESIDENT OR SENIOR MEDICAL OFFICER OF BOARD

a. SIGNATURE	b. DATE SIGNED